



## Highmark Blue Cross Blue Shield (Highmark) HEALTH PLAN APPEAL PROCESS

### For State of Delaware's Highmark Special Medicfill® Medicare Supplement Plan

DEPARTMENT OF HUMAN RESOURCES  
STATEWIDE BENEFITS OFFICE

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The Highmark Special Medicfill plan benefits are designed to follow Medicare guidelines and cover both the Medicare Part A and B deductibles, and the Part B 20% coinsurance after original Medicare makes their full payment.

In instances when the claim is denied by Medicare, Highmark will also deny the claim. Members whose claims are denied by Medicare should appeal directly to Medicare. Medicare appeal information is found in the Handbook on [Medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you).

Most services denied by Medicare are not covered by the Highmark Special Medicfill plan and therefore, can only be appealed to Medicare, not to Highmark. In instances when the claim is for services that are covered only by the State of Delaware's Highmark Special Medicfill plan (such as coverage for services outside the United States, private duty nursing, and some routine services as outlined in the Highmark Delaware Special Medicfill plan benefit booklet) the following appeal process applies:

#### **INITIAL SERVICE**

Member receives service and a claim is filed by the member (or by provider on member's behalf) with Highmark.

#### **IF DENIED and member has potential liability to provider,**

#### **LEVEL I APPEAL – ADMINISTERED BY HIGHMARK**

Member may file an appeal with Highmark within 180 days from receipt of the notice of denial to request a review of the initial claim decision.

- Highmark will review the appeal and provide a written decision\* to the member
  - Within 15 days for Pre-Service requests
  - Within 30 days for Post-Service requests

\*If additional information, documentation, or medical records are required to complete the review of the service under appeal, Highmark will notify you within the above timeframes specifying the additional information required to complete the review. Upon receipt of the additional information, Highmark shall have 15 days for pre-service requests and 30 days for post-service requests to make a determination on the appeal and provide a written decision.

#### **IF DENIAL IS UPHELD,**



## **LEVEL II APPEAL – ADMINISTERED BY HIGHMARK DELAWARE**

Member must file a Level II appeal within 60 days from receipt of the Level I appeal decision.

Note: If denial is related to urgent care, member may skip the Level II appeal and move directly to a Level III Appeal.

Highmark will review the appeal and provide a written decision\* to the member

- a) Within 15 days for Pre-Service requests
- b) Within 30 days for Post-Service requests

\*If additional information, documentation, or medical records are required to complete the review of the service under appeal, Highmark will notify you within the above timeframes specifying the additional information required to complete the review. Upon receipt of the additional information, Highmark shall have 15 days for pre-service requests and 30 days for post-service requests to make a determination on the appeal and provide a written decision.

## **IF DENIAL IS UPHELD,**

## **LEVEL III APPEAL – ADMINISTERED BY THE STATE OF DELAWARE STATEWIDE BENEFITS OFFICE (SBO)**

For medical judgment or medical necessity, the member may choose to file a Level III voluntary appeal to the SBO.

Member may file an appeal of the denial in writing to SBO within 20 days of the postmark date of the notice of denial of the Level II appeal (or within 20 days of the postmark date of the notice of denial of an expedited Level I appeal). The appeal must contain member contact information (mailing address, telephone number, etc.), a written summary of events, applicable Explanations of Benefits (EOBs), a copy of the member's Identification Card or the plan name and member's identification number (as on Identification Card), and any additional documentation member desires to provide to support his/her position. The appeal documentation must also include a fully executed State of Delaware Authorization for Release of Protected Health Information Form to provide authorization to the Statewide Benefits Office to obtain applicable information from Highmark and the SBO's Health Plan Appeal Form and Checklist, both of which are available at <https://dhr.delaware.gov/benefits/medical/highmark/appeal.shtml>.

Members submitting an appeal without a signed Authorization Form and/or completed Health Plan Appeal Form and Checklist will be requested, in writing, to submit the forms. SBO will not begin its review the appeal until it receives the Authorization Form and the Appeal Form and Checklist. The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the member and Highmark with 30 days of receiving the appeal and all necessary documentation. The request for appeal should be sent to:



Appeals Administrator  
RE: APPEAL  
Statewide Benefits Office  
841 Silver Lake Blvd.  
Suite 100  
Dover, DE 19904  
Tel: (302) 739-8331/ Fax: (302) 739-8339  
Email: [Benefits@delaware.gov](mailto:Benefits@delaware.gov)

Appeal must contain the following information: how the member may be contacted (mailing address, telephone number, etc.), a written summary of events, applicable Explanation of Benefits (EOBs), a copy of the member's Identification Card or the plan name and member's identification number (as on Identification Card), and any additional documentation member desires to provide to support his/her position. Additionally, member must sign and submit with appeal the State of Delaware's Authorization for Release of Protected Health Information to provide authorization to the Statewide Benefits Office to obtain applicable information from Highmark. This form is available at <https://dhr.delaware.gov/benefits/medical/highmark/appeal.shtml>. Members submitting an appeal without signed form will be requested, in writing, to submit form. Statewide Benefits Office will not begin to review the appeal until State of Delaware's Authorization for Release of Protected Health Information form is received.

The Appeals Administrator from the SBO (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the member and Highmark within 30 days of receiving the appeal and all necessary documentation.

**IF DENIAL IS UPHELD,**

**LEVEL IV (FINAL) APPEAL – ADMINISTERED BY THE STATE OF DELAWARE  
STATE EMPLOYEE BENEFITS COMMITTEE (SEBC)**

Member may file a written appeal to the State Employee Benefits Committee (SEBC) within 20 days of the postmark date of the notice of denial from the Level III Appeal.

Chair, State Employee Benefits Committee (SEBC)  
RE: APPEAL  
Department of Human Resources  
841 Silver Lake Blvd.  
Suite 100  
Dover, DE 19901  
Email: [SEBC@delaware.gov](mailto:SEBC@delaware.gov)

The SEBC receives the appeal and:



- a) Identifies a Hearing Officer (typically Division Director, Statewide Benefits Office). The Hearing Officer conducts a hearing and submits a report and recommendation to the SEBC within 60 days of the date of the hearing. The SEBC accepts, rejects, or modifies the recommendation and issues notice of the decision within 60 days; **OR**
- b) Hears the appeal itself and issues notice of the decision to the member within 60 days of the hearing.